GEORGIA STATE BOARD OF WORKERS' COMPENSATION

OSHA File No. | Insurer File No.

A. EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employer: World Championship | Department: TV Production | Employer Phone No.: 404-827-2066 | Insurer Name and Servicing Agent Address: K & K Insurance

Address: P.O. Box 105366 | Specific Products: Wrestling | Regular Occupation: Wrestler | Address:

City State/Zip | Nature of Business (Mfg., Trade, Transp., Etc.): Sports Entertainment | City: Fort Wayne State/Zip: IN 46801

Employee Name (Last) (First) (Middle): Bobby Walker | Date of Injury: Oct 12 1996 | Employee Social Security Number: 252 33 2657

Address: 3501 Mossywood Lane | Date of Birth: 9/04/64 | Age: 32 | Male ☒ Female ☐

City State/Zip: Rex GA 30273 | Employee's Home Ph. #: 770 507 4758 | Number of Dependents Including Spouse: 2 | County:

Place of Accident or Exposure (Address or Location): Germany

DO NOT WRITE IN THIS COLUMN
Insurer No.
SIC
Age
Sex
Occupation
County of Injury
Employer Aware
Nature
Body Part
Cause
M.O.
Controvert
D. First

On Employer's Premises: ☐ Yes ☒ No | Time of Injury: am ( ) pm ( ) | Time Workday Began | First Date Employer Aware: 11/22/96

Length of Time in Your Employ: Years (4) Months ( ) | Did Employee Work the Next Day? ☐ Yes ☒ No | First Date Employee Failed to Work a Full Day | Did Employee Receive Full Pay for Date of Injury? ☒ Yes ☐ No

Hours Worked Per Day ( ) Per Week ( ) | Number of Days Worked Per Week ( ) | List Normally Scheduled Off Days | Wage Rate at Time of Injury or Disease: Contract — Hour ( ) Day ( ) Week ( ) Mo. ( )

COMPLETE WAGE STATEMENT ON REVERSE. If employee is paid hourly, on commission or piecework basis, enter average weekly amount. | If board, lodging, or other advantages were furnished, enter average weekly amount. | If Return to Work Give Date — | Returned at What Wage ______ per week

Medical Only

How Did the Accident or Exposure Occur? Describe the Injury or Occupational Disease in Detail. Include the source of injury and indicate the part of body affected.
11/26/96 Wrestler on Road (off first visit today for (Pre)) I hurt my knee in the early part of this year on the road. I didn't do anything about it because I thought it would be okay. I reinjured it in Germany on Oct 12 1996

If Fatal: Give Date of Death

Treating Physician (Name and Address): PeachTree Ortho Clinic, Hartsfield Center (Branch), Atl. GA - 404-209-9151

Initial Treatment: ☐ No Treatment ☐ Minor: By Employer ☒ Minor: Clinic/Hospital ☐ Emergency Care ☐ Hospitalized > 24 hrs.

Hospital (Name & Address):

Report Prepared By (Print or Type): Brenda Smith | Position: TRNG Co-ord | Telephone Number: 404-351-1959 | Date of Report: 11/26/96

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

FOR USE BY INSURER/SELF-INSURER

B.

Average weekly wage $______ Weekly benefit $______ Date of disability ______ Date of first payment ______

Compensation paid: $______ Penalty paid: $______

BENEFITS ARE PAYABLE FROM ______, 19___ FOR:

☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ______% to ______ (Part of Body) for ______ weeks

UNTIL ______, 19___ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

By ______ (Insurer-Self-Insurer: Type or Print and Sign) ______ (Date) ______ (Phone)

DEFENDANT'S EXHIBIT 6

NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)

C.

Benefits will not be paid because:

By ______ (Insurer-Self-Insurer: Type or Print and Sign) ______ (Date) ______ (Phone)

WC-1 (7/94)

WCW 019710
CONFIDENTIAL

Name: WALKER, Bobby Chart Number: 15599

Date of Birth: 09/04/64 Age: 32 Date: 11/26/96

PROGRESS NOTES

NOVEMBER 26, 1996, SWS/wzlm:

HISTORY OF PRESENT ILLNESS: Bobby is a 32-year-old wrestler on the WCW Network, who was jumping off of a top rope on 10-1-96 and landed wrong, twisting his left knee. He felt a pop. He had swelling and iced it immediately. He has been wearing a brace for wrestling. He is able to wrestle and at this time states that he is 90% better. He still has some pain with full extension and pain in the popliteal area down the left leg with flexion. He occasionally feels unstable and occasionally has painful popping in his left knee.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: Left eye surgery.

MEDICATIONS: None.

ALLERGIES: None.

PHYSICAL EXAMINATION: The patient has a left knee with no effusion. There is a medial joint line tenderness at the posterior corner, however, otherwise there is no tenderness. He is non-tender laterally. There is no ligamentous instability. The calf is non-tender. Neurovascular examination of the left, lower extremity is normal.

RADIOGRAPHS: AP, lateral and sunrise radiographs of the left knee, show no apparent abnormality.

IMPRESSION AND PLAN: Twisting injury of the left knee with medial joint line tenderness at the posterior corner. He may well have a small meniscal tear, however, since he states he is 90% better and is able to wrestle, then I would favor continued conservative management. We will see him back in three to four weeks, at which time we will have another discussion. If he continues to have or starts to have severe problems, would favor an MRI of the knee and possible interventional management.

(cc: Crawford & Company----------Stephen W. Smith, M.D.)

MEDICAL REPORT

INTERIM: ____ FINAL: ____

FAILURE TO SUBMIT THIS REPORT WITHIN TEN DAYS OF FINAL TREATMENT WILL JEOPARDIZE PAYMENT OF FEES.

PRINT OR TYPE

GA. FORM WC 20a (12/85)

EMPLOYER XXX	SOC. SEC. NO. 252-33-2657	Injury Date 6/19/9
ADDRESS	DATE OF BIRTH 9/04/64	Disability Date 6/19/9
CITY STATE ZIP	INSURER FILE NO.	

EMPLOYEE
BOBBY L WALKER
ADDRESS MOSSWOOD LANE
CITY REX, GA 30273 STATE ZIP

INSURER
CRAWFORD & COMPANY
ADDRESS P BOX 52067
CITY ATLANTA, GA 30355 STATE ZIP

The above employee address will be used by the Board. Employee must report any changes.

DATE OF SERVICE	CPT/CRV CODE	MEDICAL AND SURGICAL SERVICES (ITEMIZE AND DESCRIBE)	No. of Serv.	RATE	AMOUNT	DO NOT U: THIS COLU
2. 6/26/97	99213	OFFICE VISIT			56.00	
	TOTAL:				56.00	

PLEASE COMPLETE EACH ITEM BELOW:

3. DATE DISCHARGED AS CURED: UNDETERMINED

4. DATE PATIENT STOPPED TREATMENT WITHOUT ORDER: NA

5. DATE PATIENT REFUSED TREATMENT: NA

6. DATE ABLE TO RETURN TO WORK: 6/26/97 (X) LIGHT ( ) NORMAL

7. DATE OF MAXIMUM RECOVERY: UNDETERMINED

8. VOCATIONAL REHABILITATION WILL BE ( ) NECESSARY ( ) PROBABLE ( ) UNLIKELY

9. DOES EMPLOYEE HAVE ANY PERMANENT DISABILITY RESULTING FROM THIS INJURY? (If amputation is involved, see reverse side)
If YES, describe percentage. ( ) YES ( ) NO
RETURN IN 10 DAYS, NO WRESTLING

WCW 019739
CONFIDENTIAL

10. IF EMPLOYEE HAS ANY LOSS OF VISION OR HEARING, PLEASE GIVE AMOUNT OF DISABILITY
(VISION) read on uncorrected visual acuity — Right eye ____ Left eye ____
(HEARING) Left ear 500 ____ 1K ____ 2K____
Right ear 500____ 1K ____ 2K____

11. DOCTOR'S NAME AND ADDRESS
WILLIAM GIBBONS, MD
211 CHICOPEE DRIVE
MARIETTA, GA 30060

12. DOCTOR'S I.D. NO. 58-1091021

DATE 7/03/9

SIGNATURE William S Gibbons

FROM : NORTH COBB ORTHO PHONE NO. : 7704210613 Jun. 26 2091 02:23PM P1

To: Linda Smith

OrthoCompWorks

Service of North Cobb Orthopaedic & Sports Medicine Associates, P.A.

Appointments and Information...Direct Line 770-422-3290

211 Chicopee Drive
Marietta, GA 30060

OFFICE USE ONLY:

Patient Information

Name Bobby Walker
Chart 39380
Date of Injury: 6/19/97
Date of Visit: 12/26/97
Adjuster: Pat Hadwin
Phone Number: _____
Claim Number: _____

Visit Status

Initial Visit _____
IME _____
2nd Opinion _____
Return Visit √ - MRI Results
Annual Visit _____
Final Evaluation _____

PHYSICIAN USE ONLY:

1. **Diagnosis**
   Unchanged √ ACL Tear (R) Knee
   _____
   _____

2. **Condition**
   Improving _____
   Worsening _____
   Unchanged _____

3. **Prescribed Drugs**
   A _____
   B _____
   C _____

4. **Work Status** No wrestling until Sun Date. _____
   No Work ___
   Full Time ___ Full Duty ___
   Part Time ___ Light Duty ___

5. **Care Plan**
   Next Appointment: (in weeks)
   Mon. Tues. Wed. Thur. Fri.
   Mon. Tues. Wed. Thur. Fri.
   1 2 3 4 5 6

   Weeks Months Annual PRN

   Further Treatment Recommended:

   PT PCE/FCE ESI EMG ___
   Other _____
   Surgery 2
   Referral _____
   Imaging _____

6. **Restrictions:**
   * Patient wants to think about surgery - possibly seek 2nd opinion
   _____

JUN 26 '97 12:59PM PACES FERRY IMAGING P.1/1

FROM : NORTH COBB ORTHO PHONE NO. : 7704210613 Jun. 25 2091 03:29PM P1

TO: Brenda Smith
404-351-6286

OrthoCompWorks
Service of North Cobb Orthopaedic & Sports Medicine Associates, P.A.

Appointments and Information...Direct Line
770-422-3290

211 Chicopee Drive
Marietta, GA 30060

OFFICE USE ONLY:

Patient Information

Name Bobby Walker
Chart 39380
Date of Injury: 6/19/97
Date of Visit: 6/25/97
Adjuster: Pat Hadwin (Crawford Co)
Phone Number: 404-869-2147
Claim Number: _____

Visit Status

Initial Visit ✓
IME _____
2nd Opinion _____
Return Visit _____
Annual Visit _____
Final Evaluation _____

PHYSICIAN USE ONLY:

1. **Diagnosis**
Unchanged Possible ACL Tear

2. **Condition**
Improving _____
Worsening _____
Unchanged _____

3. **Prescribed Drugs**
A _____
B _____
C _____

4. **Work Status** Light exercises only. No running, pivoting, or practicing.
No Work ___
Full Time ___ Full Duty ___
Part Time ___ Light Duty ___
MMI Date _____
PPI % Whole Man _____
Indemnity Closed ___ Yes ___ No

5. **Care Plan**
Next Appointment: (in weeks)
Mon. Tues. Wed. Thur. Fri.
Mon. Tues. Wed. Thur. Fri.
1 2 3 4 5 6
Return after MRI
Weeks Months Annual PRN
MRI 6/25/97 @ 4pm
Further Treatment Recommended:

PT PCE/FCE ESI EMG ___
Other _____
Surgery _____
Referral _____
Imaging MRI (R) Knee @ One Call

6. **Restrictions:**

Dr.'s Initials: WSG

WCW 019742
CONFIDENTIAL

PACES IMAGING

Paces Imaging - Buckhead
3193 Howell Mill Road - Suite 110
Atlanta, Georgia 30327
(404) 352-0444
Fax (404) 352-2529

Paces Imaging - Midtown
600 West Peachtree Street - Suite 140
Atlanta, Georgia 30308
(404) 875-2040
Fax (404) 874-6752

WILLIAM GIBBONS MD
211 CHICOPEE DRIVE
MARIETTA GA 30060

Patient:

Name: WALKER, BOBBY
DOB: 9/04/64
Sex: M
SSN: 252-33-2657

Date of Exam: 6/25/97

MRI OF THE RIGHT KNEE: T1 weighted coronal and parasagittal image series were obtained as were dual acquisition sagittal oblique images and finally a T2 weighted 3D volume acquisition was made for use with the ViStar.

The collateral ligaments appear normal as does the posterior cruciate ligament but the anterior cruciate ligament is completely missing. The quadriceps and patellar tendons appear intact. There is modest bony degenerative change with a little osteophytic lipping of the medial tibial plateau and medial femoral condyle. Also there are what appear to be pure chondral fractures involving the posterior aspects of both the medial and lateral femoral condyles (B12, B14; B36, B38). The retropatellar articular cartilage looks normal. I think there has been a previous partial medial meniscectomy. The remnant looks a little irregular (B14) but I do not see a residual or recurrent tear. I think the lateral meniscus is intact. There is a moderate effusion but I do not see a Baker's cyst.

CONCLUSION: THERE IS COMPLETE ABSENCE OF THE ANTERIOR CRUCIATE LIGAMENT SUGGESTING CHRONIC DEFICIENCY. ALSO I THINK THERE HAS BEEN A PREVIOUS PARTIAL MEDIAL MENISCECTOMY. THE REMNANT LOOKS A LITTLE IRREGULAR (B14). ALSO THERE ARE WHAT APPEAR TO BE PURE CHONDRAL FRACTURES OF THE ARTICULAR CARTILAGE OVERLYING THE MEDIAL (B12) AND LATERAL (B36) FEMORAL CONDYLES. FINALLY THERE IS A FAIRLY SIZEABLE JOINT EFFUSION.

S. Boyd Eaton, M.D.

da
D: 6-26-97
T: 6-26-97

NORTH COBB ORTHOPAEDIC &
SPORTS MEDICINE ASSOCIATES, P.A.
JOHN D. KNOX, JR., M.D.
ALFRED O. COLQUITT, III, M.D.
WILLIAM S. GIBBONS, M.D.
BRADLEY E. HENDERSON, M.D.
211 CHICOPEE DRIVE
MARIETTA, GEORGIA 30060
(770) 422-3290
FAX (770) 421-0613
ORTHOPEDIC SURGERY

8/25/97

MEDICAL REPORT: RE: Bobby Walker

HISTORY: This 32-year-old WCW is seen today for sprain in the right knee. Jumping off the rope, he twisted his knee on 8/19/97. He felt no discernible pop. He developed moderate swelling over the next 12-24 hours. Since that time he has had pain medially and laterally in the knee along with catching and low-grade giving way episodes. He has had previous arthroscopic surgery on this knee for what sounds like chronic subluxation of the patella.

EXAM: Reveals healthy, heavily muscled black male. He has excellent thigh tone in the right leg. There is 1+ effusion. He is tender in the anterior medial and mid lateral joint line. He has no collateral ligament laxity. He has a 2+ Lachman's with soft end-point. Pivot shift is mildly positive. Will allow about 90 degrees of flexion and McMurray's cannot be adequately tested through the range possible. Distal NV exam is normal.

X-RAYS: Negative.

IMPRESSION: Sprain, right knee, with probable tear of the anterior cruciate ligament and questionable meniscal disruption.

DISPOSITION: Advised MRI to assess the damage. Rest the knee in the meantime. Carry out gentle range of motion and isometric quad strengthening. I will see him back following the MRI for further discussion and disposition.

WILLIAM S. GIBBONS, M.D.

WSG:sbm

Chart Out
Dien 6/25/97

NORTH COBB ORTHOPAEDIC &
SPORTS MEDICINE ASSOCIATES, P.A.
JOHN D. KNOX, JR., M.D.
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WILLIAM S. GIBBONS, M.D.
BRADLEY E. HENDERSON, M.D.
211 CHICOPEE DRIVE
MARIETTA, GEORGIA 30060

CLINICAL DATA GENERAL

NAME Bobby Worrell AGE SEX S M W D

ADDRESS PHONE DATE

SPONSOR ADDRESS

OCCUPATION REF BY ACKN

6/26/97 MRI Results:

6-26-97 PROGRESS NOTE: Bobby received MRI yesterday, which showed ACL deficiency. There was burning of the medial meniscus which was felt to be likely consistent with a previous meniscectomy. Taking these findings into account, one would wonder if his previous knee surgery was not a partial medial meniscectomy, at which time, ACL damage was noted in that he is now gone on to developed increased laxity and symptomatic problems with the knee in that regard. I would certain, in either regard, recommend arthroscopic ACL reconstruction for the reasons stated in his original note. The pros and cons of this are discussed, along with the down time involved. I have suggested he work for the next week to ten days on getting range of motion and quad strengthening going in his knee. This would be appropriate before surgery is undertaken in any regard. In the meantime, he may well want to get other opinions on this before deciding on a definite course of action. I will tentatively plan to see him back in 10 days for re-evaluation. WCW will be aware of the MRI findings and recommendations.
WSG:kw

FEDERAL ID (58181414)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OSHA File No.

Insurer File No.

A. Employer: WORLD CHAMPIONSHIP WRESTLING, One CNN Center, Box [illegible], Atlanta, GA [illegible]

Address / City / State/Zip

Department: WCW

Employer Phone No.: 404-603-1030 (Voice Mail)

Specific Products: TBS Production

Regular Occupation: Contract Wrestler

Nature of Business (Mfg., Trade, Transp., Etc.): Sports Entertainment

Insurer/Self Insurer Name:

Servicing Agent Name & Address:

City / State/Zip:

Date of Injury: 2/27/98

Employee Social Security Number: 256-33-2607

Employee Name (Last) (First) (Middle): WALKER, BOBBY

Date of Birth: 9/4/64

Age: 32

Male: X   Female: ☐

Address: 59 GlenEagle Dr.

City: Fayetteville State/Zip: GA 30214

Employee's Home Ph. #: 770-716-6830

Number of Dependents Including Spouse: -4-

County: Fulton

Place of Accident or Exposure (Address or Location): WCW Training Center

On Employer's Premises: X Yes ☐ No

Time of Injury: 12:00 PM

Time Workday Began: 9 AM

First Date Employer Aware: 2/27/98 — kept training, hoping to get better

Length of Time in Your Employ: Years (5) Months ( )

Did Employee Work the Next Day? ☐ Yes X No

First Date Employee Failed to Work a Full Day:

Did Employee Receive Full Pay for Date of Injury? ☐ Yes ☐ No

Hours Worked Per Day: Varies Per Week: Varies

Number of Days Worked Per Week: Varies

List Normally Scheduled Off Days: Varies

Wage Rate at Time of Injury or Disease: Contract — Hour ( ) Day ( ) Week ( ) Mo. ( )

COMPLETE WAGE STATEMENT ON REVERSE. If employee is paid hourly, on commission or piecework basis, enter average weekly amount: Contract Wrestler - Reported Pain approx 2 weeks

If board, lodging, or other advantages were furnished, enter average weekly amount:

If Returned to Work, Give Date:

Returned at What Wage: ______ per week

How Did the Accident or Exposure Occur? Describe the Injury or Occupational Disease in Detail. Include the source of injury and indicate the part of body affected: During Matches @ WCW Power Plant - Injury to Right Knee. Surgery Scheduled for 3/27 - (Right Knee)

If Fatal: Give Date of Death

Treating Physician (Name and Address): Michael Ciepela, 3280 Howell Mill Rd, Atl. GA.

Initial Treatment:
☐ No Treatment
☐ Minor: By Employer
☐ Minor: Clinic/Hospital
☐ Emergency Care
☐ Hospitalized > 24 hrs.

MCO Yes ☐ No ☐

Hospital (Name & Address):

DO NOT WRITE IN THIS COLUMN: Insurer No. / SIC / Age / Sex / Occupation / County of Injury / Employer Aware / Nature / Body Part / Cause / M.O. / Controvert / D. First

Report Prepared By (Print or Type): Brenda Smith

Position: Training Center

Telephone Number: 404-603-1030 (Voice Mail only)

Date of Report: 3/26/98

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

FOR USE BY INSURER/SELF-INSURER

B.

Average weekly wage: $________ Weekly benefit: $________ Date of disability: ________ Date of first payment: ________

Compensation paid: $________ Penalty paid: $________

BENEFITS ARE PAYABLE FROM ________, 19____ FOR:

☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ______% to ______ (Part of Body) for ______ weeks

UNTIL ________, 19____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

By ________ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)

WCW 019813
CONFIDENTIAL

Benefits will not be paid because:

By ________ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-1 (7/96)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

A.

OSHA File No.:
Insurer File No.: 678-72396

Employer: PCW
Employer Phone No.: 404-346-1189
Insurer/Self Insurer Name: TG
Employer FEIN: 58-1811414
TPA/Claims Office: Crawford & CO
TPA FEIN: 58-0506554
Address: P O Box 105366
Nature of Business (Mfg., Trade, Transp., Etc.):
Address: P O Box 5095
City: Atlanta State/Zip: GA 30348
City: State/Zip:
City: Atlanta State/Zip: GA 31302
Employer Location Address (If Different): Same
TPA/Claims Office Phone No.: 678-443-3663
Place of Accident or Exposure (Address or Location):
County: Fulton
Employee Name (Last) (First) (Middle): WALKER, BOBBY
Date of Birth: 9-4-64
Male ☒ Female ☐
Employee Social Security Number: 256-33-2657
Address: 59 Gold Eagle Drive
City: Fayette State/Zip: GA 30214
Employee's Home Ph. #:
Number of Dependents Including Spouse: 0
DO NOT WRITE IN THIS COLUMN
Insurer No.:
Date of Injury: 2-27-98
Time of Injury: 12:30 am ☐ am ( ) pm ( )
Time Workday Began:
Date Employer Notified: 2-27-98
SIC:
Date Hired: 1-93
Did Employee Work the Next Day? ☐ Yes ☒ No
First Date Employee Failed to Work a Full Day: 2-28-98
Did Employee Receive Full Pay for Date of Injury? ☒ Yes ☐ No
Date of Birth:
Hours Worked Per Day (Varies) Per Week ( )
Number of Days Worked Per Week (0)
List Normally Scheduled Off Days: Varies
Wage Rate at Time of Injury or Disease: Contract Hour ( ) Day ( ) Week ( ) Mo. ( )
Sex:
COMPLETE WAGE STATEMENT ON REVERSE: If employee is paid hourly, on commission or piecework basis, enter average weekly amount
$
If board, lodging, or other advantages were furnished, enter average weekly amount
$
County of Injury:
Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☒ No ☐
Type of Injury/Illness: Knee Injury
Part of Body Affected: Knee
Employer Aware:
How Injury or Illness/Abnormal Health Condition Occurred: During Match Twisted Rt Knee.
Nature:
If Returned to Work, Give Date: N/A
Returned at What Wage per Week
If Fatal: Give Date of Death
Body Part:
Treating Physician (Name and Address): Dr Cibula 3280 Howell Mill Rd Atlanta GA 30327
Initial Treatment: ☐ No Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐ Hospitalized > 24 hrs.
MCO Yes ☐ No ☐
Hospital (Name & Address): Unknown
Cause:
M.O.:
Controvert:
D. First:
Report Prepared By (Print or Type): Don Berg
Position: Claims Manager
Telephone Number: (919) 459-5025
Date of Report: 4-1-98

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

B. FOR USE BY INSURER/SELF-INSURER

Average weekly wage: $
Weekly benefit: $325.33
Date of disability: 2-27-98
Date of first payment:
Compensation paid: $ —
Penalty paid: $ —
Previously Medical Only Yes ☐ No ☐
BENEFITS ARE PAYABLE FROM 2-27, 1998 FOR: Employee elected salary in lieu of work comp
☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of % to Part of Body for weeks
UNTIL 19 WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.
By Sonya B Chapin (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) 4-29-98 (Date) 678-443-3663 (Phone) (Extension)

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION (over for additional information)

Benefits will not be paid because:
By (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-1 (7/97)

MEDICAL O...

WCW 019821
CONFIDENTIAL

MICHAEL CIEPIELA M D
3280 HOWELL MILL RD
SUITE 110
ATLANTA GA 30327

Patient:

Name: WALKER, BOBBY
DOB: 9/04/64
Sex: M
SSN: 252-33-2657

Date of Exam: 3/19/98

MRI OF THE RIGHT KNEE:

HISTORY: Injury.

T1 coronal and multi-echo sagittal views of the knee were obtained. 3-D FT acquisitions were also obtained for ViStar manipulation.

The patient had a previous exam here approximately one year prior.

On today's study, there is again evidence of a partial medial meniscectomy as most of the medial meniscus has been removed. As stated in the previous report, the remaining remnant is somewhat irregular but I am unable to definitely substantiate a recurrent tear. The lateral meniscus remains intact.

There is also once again noted to be an absence of the anterior cruciate ligament consistent with a chronic deficiency. The posterior cruciate ligament as well as the patellar and quadriceps tendons appear intact. The medial and lateral collateral ligaments appear unremarkable.

There is no evidence of an acute bone injury as I do not see evidence of a bone bruise or microfracture. Since previous exam the patient has developed several small focal areas of osteosclerosis involving the articular surface of both the medial and lateral femoral condyle.

The predescribed pure chondral fractures involving the posterior

continued:

aspects of both the medial and lateral femoral condyles have somewhat healed since previous exams. Evidence of the previous chondral fractures are still seen on image C12, C34. The chondral fractures have healed, however, there is some resultant thinning of the articular cartilage on both the medial and lateral compartments consistent with grade IV chondromalacia. There is an associated joint effusion but I do not see evidence of a Baker's cyst.

IMPRESSION: NO ACUTE ABNORMALITIES HAVE DEVELOPED SINCE STUDY OF ONE YEAR PRIOR. THERE IS EVIDENCE OF AN ALMOST COMPLETE MEDIAL MENISCECTOMY. I DO NOT SEE EVIDENCE OF AN ACUTE MENISCUS TEAR. THERE IS AN ABSENCE OF THE ANTERIOR CRUCIATE LIGAMENT CONSISTENT WITH CHRONIC DEFICIENCY. THE PREVIOUS DESCRIBED CHONDRAL FRACTURES INVOLVING THE POSTERIOR ASPECT OF THE MEDIAL AND LATERAL FEMORAL CONDYLES HAVE ESSENTIALLY HEALED. THERE IS SOME RESULTANT THINNING OF THE ARTICULAR CARTILAGE ON THE MEDIAL AND LATERAL JOINT COMPARTMENTS CONSISTENT WITH GRADE IV CHONDROMALACIA.

Jerry Domescik, M.D.

da
D: 3-20-98
T: 3-20-98

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CRAWFORD AND COMPANY
WCW
PO BOX 52067
ATLANTA GA 30355 0067

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (Mem File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER: 252332657

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WALKER BOBBY L

3. PATIENT'S BIRTH DATE MM DD YY: 09 04 64 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 59 GLENEAGLE DR

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: FAYETEVILLE | STATE: GA

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

ZIP CODE: 30214 | TELEPHONE (Include Area Code): (770) 716 6834

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NA

10. IS PATIENT'S CONDITION RELATED TO:
a. EMPLOYMENT? (CURRENT OR PREVIOUS) X YES | NO
b. AUTO ACCIDENT? YES | X NO | PLACE (State)
c. OTHER ACCIDENT? YES | X NO

11. INSURED'S POLICY, GROUP OR FECA NUMBER: WCW

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME: CRAWFORD AND COMPANY

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO If yes, return to and complete item 9 a-

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 7 30 98

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE 7 30

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO

RECEIVED B
SEP 08 1998

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 844 2
2.
3.
4.

23. PRIOR AUTHORIZATION NUMBER: K & K CLAI

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL
1 07 30 98	07 30 98	11	1	97110		844.2	40 00	1				
2 07 30 98	07 30 98	11	1	97112		844.2	45 00	1				
3 07 30 98	07 30 98	11	1	97530		844.2	48 00	1				
4												
5												
6												

RECEIVED
AUG 11 1998
BY

WCW 019725
CONFIDENTIAL

25. FEDERAL TAX I.D. NUMBER: 58 2157687 | SSN | EIN X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES | NO

28. TOTAL CHARGE: $ 133 00

29. AMOUNT PAID: $ 0 00

30. BAL $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROSS BRAKEVILLE PT
GA 2536
SIGNED | DATE 08 04 98

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
ASRC INTEGRA
3280 HOWELL MILL RD SU
ATLANTA GA 30327

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
ATLANTA SPINE AND REHA
3280 HOWELL MILL RD S
ATLANTA GA 30327
PIN # | GRP #

PLEASE PRINT OR TYPE

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90)

FORM HCFA-1500 (U2) (12-
FORM OWCP-1500 FO
APPROVED OMB-0938-00C

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CRAWFORD AND COMPANY
WCW
PO BOX 52067
ATLANTA GA 30355 0067

HEALTH INSURANCE CLAIM FORM

PICA

ALIGN BY TYPING AN X IN BOX

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER: 252332657 (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WALKER BOBBY L

3. PATIENT'S BIRTH DATE MM DD YY: 09 04 64 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 59 GLENEAGLE DR

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: FAYETEVILLE | STATE: GA

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 30214 | TELEPHONE (Include Area Code): (770) 716 6834

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NA

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER: WCW

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): X YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M F

b. AUTO ACCIDENT? YES | X NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CRAWFORD AND COMPANY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO | If yes, return to and complete item 9 a-

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE: 7 28 98

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE 7 28

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY | FROM | TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY | FROM | TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO | $ CHARGES

RECEIVED B

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 844 2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

SEP 08 1998

23. PRIOR AUTHORIZATION NUMBER

K&K CLM

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED LOCAL
1 07 28 98	07 28 98	11	1	97110		844.2	40 00	1				
2 07 28 98	07 28 98	11	1	97112		844.2	45 00	1				
3 07 28 98	07 28 98	11	1	97530		844.2	48 00	1				
4												
5												
6												

WCW 019726
CONFIDENTIAL

25. FEDERAL TAX I.D. NUMBER: 58 2157687 | SSN | EIN: X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ 133 00

29. AMOUNT PAID: $ 0 00

30. BAL: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

ROSS BRAKEVILLE PT
GA 2536
SIGNED | 08 04 98 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

ASRC INTEGRA
3280 HOWELL MILL RD SI
ATLANTA GA 30327

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

ATLANTA SPINE AND REHA:
3280 HOWELL MILL RD S
ATLANTA GA 30327

PIN # | GRP #

PLEASE PRINT OR TYPE

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 12/90

FORM HCFA-1500 (U2) 12-
FORM OWCP-1500 FOR
APPROVED OMB-0938-000

Patient

Therapist

Physician

Treatment/Dx Code(s)

☐ PT ☐ OT ☐ SLP ☐ Psych

Progress Notes

Date	
7-28-98	States doing D.I.L. c̄ progression, slowly ↑ strength
	ROM (R) -1-2° Both ✓ 5 / c̄ capsular end feel
	Strength: Knee / #60 (L) 18 (R) 16 pain PFJ 4/10
	Knee ✓ #60 (L) 8 (R) 10
	Retro step ups 30 sec (L) 16 (R) 12 pain lat. knee 5/10
	Rx sheet c̄ addition of kinematic drills
	Pt cont to c/o [illegible] lat aspect of knee.
	Plan to cont to progress PR
7-30-98	Rx / 7-28-98 p̄ MD ✓ will start [illegible] for [illegible] act
	lat knee pain as we progress c̄ [illegible] PR

WCW 019727
CONFIDENTIAL

Q-8-47

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

CRAWFORD AND COMPANY
WCW
PO BOX 52067
ATLANTA GA 30355 0067

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)	252332657
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): WALKER BOBBY L	3. PATIENT'S BIRTH DATE MM DD YY: 09 04 64 SEX: M [X] F [ ]
5. PATIENT'S ADDRESS (No., Street): 59 GLENEAGLE DR	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
CITY: FAYETEVILLE STATE: GA	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
ZIP CODE: 30214 TELEPHONE (Include Area Code): (770) 716 6834	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NA	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) [X] YES [ ] NO
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M [ ] F [ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
7. INSURED'S ADDRESS (No., Street): SAME	
CITY	STATE
ZIP CODE	TELEPHONE (INCLUDE AREA CODE) ( )
11. INSURED'S POLICY GROUP OR FECA NUMBER: WCW	
a. INSURED'S DATE OF BIRTH MM DD YY	SEX M [ ] F [ ]
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME: CRAWFORD AND COMPANY	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE 7 14 98
SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE ON FILE 7 14 98
SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 8 19 97	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: MIKE CIEPELLA GA	17a. I.D. NUMBER OF REFERRING PHYSICIAN: F75539	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 844.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: K & K CLAIMS

RECEIVED BY SEP 08 1998

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS : MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 14 98 07 14 98	11	1	97110	844.2	40.00	1				
2 07 14 98 07 14 98	11	1	97112	844.2	45 00	1				
3 07 14 98 07 14 98	11	1	97530	844.2	48 00	1				
4										
5										
6										

WCW 019728
CONFIDENTIAL

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [Y] YES [ ] NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
58 2157687 [ ] [X]			$ 133 00	$ 0 00	$ 133 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ROSS BRAKEVILLE PT	ASRC INTEGRA	ATLANTA SPINE AND REHAB CTR
GA2536 SIGNED 07 16 98 DATE	3280 HOWELL MILL RD SI	3280 HOWELL MILL RD SUITE 1
	ATLANTA GA 30327	ATLANTA GA 30327
		PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

Therapist ______________

Patient Name B. Walker

Physician ______________

X PT ☐ OT ☐ SLP ☐ Psych

Treatment/Dx Code(s) ______________

Date	Progress Notes
6-4-98	States cont. to improve. Up to 2x75 ē Non Wt. squats. ROM P, NOBS - full ē ✓ & ↓ muscle tone 3-/4. Rx/sheet ē ↑ act. Pt tol Rx well & s̄ c/o. Plan to cont. ē protocol. [signature]
6-8-98	States s̄ c/o. Rx/sheet Pt tol well. Cont ē same act ē ↑ intensity until wk 11-12 & will start plyometrics. [signature]
6-16-98	Pt states doing good. Rx/sheet ē beginning ↑ slide board forward & backward & over-a-line jumping. Pt tol well. Will monitor effusion & progress ē act & intensity for Arthrokinematic/proprioception. [signature]
6.23.98	Pt states worked ē T-mill 20 min yesterday s̄ pain. Rx today/sheet but tender Ant/Med jt ē T-mill & was sore p̄ Rx. Instructed pt. to ↓ intensity until pain is gone & ↓ ambulation ē T-mill. [signature]
6/30	No c/o pain, cont ē Rx sheet. ↑ act. next visit. [signature]
7-14-98	States 7-10 - was working out ē supersets & ↑ wt ē subsequent irritation of Ⓡ knee. Rx ē ice & ↓ act since. Today ✓ ROM ↓ to 115°. Rx/sheet ē ↓ intensity. Pt. has grade I effusion. Plan to progress as s̄ s̄ tol. [signature]

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CRAWFORD AND COMPANY
WCW
PO BOX 52067
ATLANTA GA 30355 0067

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 252332657

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3. PATIENT'S BIRTH DATE MM DD YY: 09 04 64 | SEX: M X | F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 59 GLENEAGLE DR

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: FAYETEVILLE | STATE: GA

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 30214 | TELEPHONE (Include Area Code): (770)716 6834

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NA

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER: WCW

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): X YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M | F

b. AUTO ACCIDENT? YES | X NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CRAWFORD AND COMPANY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE | DATE: 9 08 98

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17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 844 2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09 08 98 | 09 08 98	11	1	97110		844.2	40 00	1				
2	09 08 98 | 09 08 98	11	1	97112		844.2	45 00	1				
3												
4												
5												
6												

RECEIVED BY OCT 05 1998 K&K CLAIMS

25. FEDERAL TAX I.D. NUMBER: 58 2157687 | SSN | EIN: X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Y YES | NO

28. TOTAL CHARGE: $ 85 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 85 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROSS BRAKEVILLE PT
GA 2536 | SIGNED | DATE: 09 18 98

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
ASRC INTEGRA
3280 HOWELL MILL RD SI
ATLANTA GA 30327

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ATLANTA SPINE AND REHAB CTR
3280 HOWELL MILL RD STE 123
ATLANTA GA 30327

PIN # | GRP #

PATIENT AND INSURED INFORMATION

INFORMATION OF SUPPLIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90) PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90) FORM OMCP-1500 FORM RRB-1500 APPROVED OMB-0938-0008

WCW 019730
CONFIDENTIAL

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CRAWFORD AND COMPANY
WCW
PO BOX 52067
ATLANTA GA 30355 0067

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

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6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: FAYETEVILLE | STATE: GA

8. PATIENT STATUS: Single | Married | Other | Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: 30214 | TELEPHONE (Include Area Code): (770)716 6834

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): NA

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY, GROUP OR FECA NUMBER: WCW

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): X YES | NO

a. INSURED'S DATE OF BIRTH (MM DD YY) | SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) | SEX: M | F

b. AUTO ACCIDENT? YES | X NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: CRAWFORD AND COMPANY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE 9 10 98
SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE 9 10 98
SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (MM DD YY)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | X NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 844 2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 10 98	09 10 98	11	1	97110		844.2	40 00	1				
2 09 10 98	09 10 98	11	1	97112		844.2	45 00	1				
3 09 10 98	09 10 98	11	1	97530		844.2	48 00	1				
4												
5												
6												

RECEIVED BY
OCT 05 1998
K&K CLAIMS

25. FEDERAL TAX I.D. NUMBER: 58 2157687 | SSN | EIN: X

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Y YES | NO

28. TOTAL CHARGE: $ 133 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 133 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
ROSS BRAKEVILLE PT
GA 2536 09 18 98
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
ASRC INTEGRA
3280 HOWELL MILL RD SI
ATLANTA GA 30327

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
ATLANTA SPINE AND REHAB CTR
3280 HOWELL MILL RD STE 123
ATLANTA GA 30327

PIN # | GRP #

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 12/90) PLEASE PRINT OR TYPE

FORM HCFA-1500 (U2) (12-90) FORM RRB-1500
FORM OWCP-1500
APPROVED OMB-0938-0008 CR - 8

WCW 019731
CONFIDENTIAL

Patient Name BOBBY WALKER

Therapist _____

Physician _____

☐ PT ☐ OT ☐ SLP ☐ Psych

Treatment/Dx Code(s) _____

Date	Progress Notes
9-10-98	STATES DOING FINE C/O 4/D RX 9-B PLAN TO START TESTING IN PREP FOR D/C. RJ

RECEIVED BY
OCT 05 1998
K&K CLAIMS

Lifetime Authorization

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to Georgia Medical Resources, Inc., for any service furnished me by Georgia Medical Resources, Inc. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, CHAMPUS and its agents, or any private insurance company any information needed to determine these benefits or benefits for related services. I understand that I am responsible for payment of all deductible and co-insurance charges.

Medicare Number _____

Name of Beneficiary Bobby Walker

BENEFICIARY'S SIGNATURE: (OR AUTHORIZED CAREGIVER IF BENEFICIARY UNABLE TO SIGN) X _____

IF BENEFICIARY CANNOT SIGN FORM, PLEASE STATE REASON WHY: _____

AUTHORIZED CAREGIVER'S RELATIONSHIP TO BENEFICIARY: _____

DATE: 3/28/98

SEND PAYMENTS TO:
Georgia Medical Resources, Inc.
718 CHEROKEE STREET
MARIETTA, GA 30060
(404) 428-5445

WAIVER OF LIABILITY

"Medicare will only pay for services that it determines to be 'reasonable and necessary' under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (specify particular service(s)) for the following reasons:"

"I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.
Signed, "

Beneficiary signature _____ Date _____

I acknowledge that this form is subject to all of the terms set forth on the reverse side, which terms are hereby incorporated by reference, and made a part of this agreement between Georgia Medical Resources, Inc. and myself. I further acknowledge that I have read and understand all of the terms appearing above and on the reverse side, INCLUDING THE DISCLAIMER OF WARRANTIES and the USE OF EQUIPMENT AND SUPPLIES, and that I have received a complete copy of this form. I have inspected and found the equipment above to be in good working order. I have been instructed in the use of this equipment.

x C. Pauk PT
THERAPIST SIGNATURE

x Bobby Walker
PATIENT'S SIGNATURE

CERTIFICATE OF MEDICAL NECESSITY

Patient Name Walker, Bobby D.O.B. 9/9/64 Sex M S.S.# 252-33-2655

Patient Address 59 Gleneagle Drive Phone # (770) 716-6830

City Fayetteville State GA Zip 30214

Insurance Carrier K & K Insurance Policy # _____

Address _____ Group # _____

City _____ State _____ Zip _____ Phone # _____

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K & K CLAIMS

✓ Diagnosis (R) knee ACL repair (3649) Length of need 3 to 4 mths.

✓ Prognosis: X Good ____ Fair ____ Guarded ____ Poor

Following physician certification is needed to authorize equipment required by your patient for use at home. Please provide the information requested. sign, date where indicated and return to us. Thank you.

( ) **Cane Adj. FX with tip** – Patient's condition impairs ambulation

( ) **Cane Quad.** – Patient's condition impairs ambulation

( ) **Commode Chair** – Patient confined to single room or level of home

( ) **Walker Folding** – Patient's condition impairs ambulation - walker is for therapy

( ) **Walker Platform Attachment** – Upper body weakness ____ right side ____ left side

( ) **Wheel Attachment Walker** – Upper body weakness ____ right side ____ left side

(X) **Crutch** – Patient's condition impairs ambulation

( ) **Other** _____

✓ I, the undersigned, certify that the above prescribed equipment is medically necessary for this patient's well being. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is not prescribed as convenience equipment. PHYSICAN INFORMATION:

Name Dr. Gupta, Michael Signature X Michael D Gupta MD Date 5-4-98

Address 3280 Howell Mill Rd. Ste. 110 Atlanta, GA 30327

WCW 019734
CONFIDENTIAL

World Championship Wrestling

History and Physical Examination Record for License as a Wrestler

☐ First application for license ☐ Renewal application

STATEMENT OF APPLICANT

1. LEGAL NAME: Brian, WALKER — DATE OF APPLICATION: 8/3/99

ADDRESS (Street, City, State, ZIP): [illegible] drive — DATE OF BIRTH: 9/14/64

RING NAME PROFESSIONALLY: [illegible] — OTHER STATES IN WHICH LICENSED TO OFFICIATE

2. Have you ever served in the U.S. Armed Forces? ..... NO ..... ☒ No ☐ Yes*
   - If you received a medical discharge, state reason:

3. Do you suffer from headaches, blurred or defective vision, dizziness or impaired memory? ..... ☒ No ☐ Yes*

4. Do you suffer from shortness of breath, pounding (palpitation) of the heart, any pain or pressure in the chest, or have you ever been told that you had any disease of the heart? ..... ☒ No ☐ Yes*

5. Have you ever spat blood, or been told that you had any disease of the lungs? ..... ☒ No ☐ Yes*

6. Have you ever been advised to have any special examinations such as x-rays, electrocardiogram, electroencephalogram, blood examination, etc. ..... ☒ No ☐ Yes*

7. Have you ever fractured any bones, or suffered any back, neck or other injuries? ..... ☒ No ☒ Yes*

8. Have you had illnesses, diseases, accidents, or surgical operations within the past five years? ..... ☐ No ☒ Yes*

9. Have you any other information concerning your health, past or present, which is not covered by the above questions? ..... ☒ No ☐ Yes*

*If Yes to Item 3-9, state details: had KNEE Repaired - April 98 - ACL repair done well.

I hereby certify that to the best of my knowledge and belief the above statements are true and correct, and realize that any deliberate misstatement will subject me to disciplinary action. I hereby authorize WCW, Inc. in writing or verbally to receive and/or discuss and/or disclose to any state athletic commission or other governmental regulatory authority or any third party on a "need to know" basis copies of any and all of my licensing, medical and/or hospital records or other information. This authorization shall remain in effect until you receive written notice of revocation by me, which revocation cannot and will not apply to any and all licensing, medical and/or hospital records or information requested, received and/or disseminated by WCW prior to actual receipt of such written revocation. Finally, a photocopy of this authorization shall be deemed to have the same effect as this original.

I hereby give my consent to have my blood tested for HIV syndrome and any other bloodwork deemed necessary by the physician.

Signature of Applicant [signature] Date _____

Signature of Physician [signature] Date 8/31/99

PHYSICAL EXAMINATION

1. Height 6'0" Weight 235 Temp. (Oral) 96.8
2. Eyes: Pupils, Regular N Equal N ; React to light and accommodation N ;
   Conjunctivae, Right eye N Left eye N ;
   Cornea, Right eye N Left eye N ;
   Retinae, *if not examined, so indicate*, Right eye 20 Left eye 20
   Snellen chart vision (uncorrected) Right eye 20/40 Left eye 20/40
   (corrected) Right eye _____ Left eye _____
3. Orientation: date ☒ Yes ☐ No place ☒ Yes ☐ No person ☒ Yes ☐ No
   Memory: recent and remote events ☒ Yes ☐ No
   Other psychiatric abnormalities: ☒ None ☐ Any - Describe _____
4. Head: any deformities or areas of tenderness: ☒ None ☐ Any - Describe _____
5. Periorbital margins: any recent scars, tenderness or swelling ☒ None ☐ Any – Describe _____

6. Ears: Auditory canals, Right ✓ Left ✓; Ear drums, *if drums are not visualized because of cerumen, so state*
Right N Left N Discharge None Mastoid tenderness None
Auditory acuity for conversational voice; *indicate if normal or grossly impaired*: Right ear Left ear
7. Nose: X Normal ☐ Abnormal - Describe
8. Oropharynx: X Normal ☐ Abnormal - Describe
Tongue: X Normal ☐ Abnormal - Describe
Gums X Normal ☐ Abnormal - Describe
Teeth X Normal ☐ Abnormal - Describe
9. Neck: X Normal ☐ Abnormal - Describe
10. Thorax: Lungs: Fremitus X Normal ☐ Abnormal - Describe
Percussion note X Normal ☐ Abnormal - Describe
Asculatory findings: X Normal ☐ Abnormal - Describe
Heart and Cardiovascular system: Apex location by interspace 5th; inside , at ✓, or outside
Midclavicular line ✓; Quality of heart sounds X Good ☐ Fair ☐ Poor
Rhythm: X Regular ☐ Irregular - Describe
Arrhythmia or thrills present: X No ☐ Yes - Describe:
Murmurs present X No ☐ Yes - Describe: Systolic or diastolic , Location of max intensity
Direction of transmission: Describe quality
Resting ventricular rate 85 Resting radial pulse rate 85 Resting blood pressure 112/82
Pulse rate immediately after exercising: *20-bendings* 2 min. after exercise Blood pressure 3 min. after exercise
11. Abdomen: X Normal ☐ Abnormal - Describe
Scars, herniations, tender areas, or masses: X No ☐ Yes - Describe
Liver, spleen and kidneys (note any enlargement or tenderness): X Normal ☐ Abnormal - Describe
Inguinal region (note any tenderness, masses, scars or hernias): X Normal ☐ Abnormal - Describe
Genitalia: Penis: X Normal ☐ Abnormal - Describe
Testes: X Normal ☐ Abnormal - Describe
12. Rectum: Note any fissures, fistulae, hemorrhoids, pilonidal cyst, prostatic pathology etc. X Normal ☐ Abnormal - Describe
Rectal not performed
13. Skin: X Normal ☐ Abnormal - Describe
Lymphatic system (Examine cervical, maxillary, supraclavicular, axillary, epitrochlear, and inguinal node groups for adenopathy):
X Normal ☐ Abnormal - Describe
Lymphangitis present: ☐ No ☐ Yes - Describe
Status Thymico-Lymphaticus (note any sparse distribution of hair, soft skin, contour of thighs, generalized glandular enlargement, etc):
X Present ☐ Absent - Describe
14. Neurological: Gait X Normal ☐ Abnormal Rhomberg ☐ Normal ☐ Abnormal Finger to nose test ☐ Normal ☐ Abnormal
Knee jerks X Normal ☐ Abnormal; Biceps jerks ☐ Normal ☐ Abnormal; Babinski ☐ Normal ☐ Abnormal; Brudzinski ☐ Normal ☐ abnormal
Describe any abnormalities
15. Musculoskeletal System: Posture X Normal ☐ Abnormal - Describe
Spinal curvature X Normal ☐ Abnormal - Describe
Any spinal tenderness, deformity, or limitation of motion: X No ☐ Yes - Describe
Extremities (note any deformity, pilonidal cyst, prostatic pathology, etc): X Normal ☐ Abnormal - Describe
Scar, arthros., Rt knee good ligament Strength.
16. Obligatory laboratory data:
Urinalysis: S.G. 1.015 reaction ✓ sugar N albumin + 2
HIV: X Negative ☐ Positive (Please attach original test results) EKG (Please attach original test results)
17. Additional laboratory data shall be collected if determined to be necessary by the physician (Please attach test results):
Microscopic Examination, X-ray of the chest, chemistry panel, any recent laboratory data available. See chart EKG attached
18. If wrestler is 36 years or older additional obligatory data required:
Serology: CBC VDRL/RPR Hepatitis B
Summarize all positive findings, if any, and indicate your clinical interpretation of this data:

Recommendations for further specialized examination and/or consultation:

STATEMENT OF PHYSICIAN

I hereby certify that I have examined Bobby Walker
at my office ☐ elsewhere X on this 3 day of Aug 19 99, and
X have approved him for Wrestling
☐ have not approved him for Wrestling and do not recommend further studies because of obvious clinical disease
☐ Other remarks

CONCENTRA MEDICAL CENTER
3680 ATLANTA AVENUE
HAPEVILLE, GA. 30354

T.L. Lipscomb MD
Physician Name

Office Address

404-768-3351
Office Phone

Physician Signature

3 Aug 99
Date

WCW 018425
CONFIDENTIAL

Attn: Vickie ...

A.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

OSHA File No.	
Insurer File No.	
TPA/Claims Office	
TPA FEIN	
Address	
City / State/Zip	
TPA/Claims Office Phone No.	
County of Injury	
Employee Social Security Number	256-33-2657

Employer: WORLD CHAMPIONSHIP WRESTLING
Employer Phone No.:
Insurer/Self Insurer Name: SPORTS ENTERTAINMENT
Address: 2865 LOG CABIN DRIVE
Employer FEIN: 581-811-414
City / State/Zip: SMYRNA, GA 30080
City: State/Zip:
Employer Location Address (If Different):
Place of Accident or Exposure (Address or Location):
Occupation: wrestler
Employee Name (Last) (First) (Middle): Walker, Bobby (Fax) 716-6842
Date of Birth: 9-4-64
Date of Injury: 2-2-00
Address: 59 Glen Eagles Drive
City / State/Zip: Fayetteville GA 30215
Employee's Home Ph. #: 770-716-0830
Number of Dependents Including Spouse: 4
Male: X Female: ☐
Time of Injury: 8:00 PM
Time Workday Began: am ( ) pm (✓)
Date Employer Notified: 2-3-00
Date Hired: Aug 1994
Did Employee Work the Next Day? ☐ Yes ✓ No
First Date Employee Failed to Work a Full Day: 2-3-00
Did Employee Receive Full Pay for Date of Injury? ✓ Yes ☐ No
Hours Worked Per Day / Per Week: Varies
Number of Days Worked Per Week: Varies
List Normally Scheduled Days Off: Varies
Wage Rate at Time of Injury or Disease: Contract — Per Hour ( ) Day ( ) Week ( ) Month ( )
COMPLETE WAGE STATEMENT ON REVERSE: If employee is paid hourly, on commission or piecework basis, enter average weekly amount $ Contract Med. Only
If board, lodging, or other advantages were furnished, enter average weekly amount $
Did Injury/Illness Exposure Occur on Employer's Premises? Yes ☐ No ✓
Type of Injury/Illness: twisted
Part of Body Affected: (L) knee
How Injury or Illness/Abnormal Health Condition Occurred: Twisted knee while wrestling
If Fatal: Give Date of Death
If Returned to Work, Give Date
Returned at What Wage per Week
Treating Physician (Name and Address): Dr. Ciepiela, 3280 Howell Mill Rd. Atlanta, GA 30327 (404) 355-0685 — * Appt. 5/4 2:30p
Initial Treatment: ✓ No Treatment ☐ Minor: By Employer ☐ Minor: Clinic/Hospital ☐ Emergency Care ☐ Hospitalized > 24 hrs.
MCO Yes ☐ No ☐
Hospital (Name & Address):
Report Prepared By (Print or Type): Debbie Henderson
Position: WCW Coor.
Telephone Number: 404-603-3118
Date of Report: 2-3-00

DO NOT WRITE IN THIS COLUMN
Insurer No.
SIC
Date of Birth
Sex
County of Injury
Employer Aware
Nature
Body Part
Cause
M.O.
Controvert
D. First

EMPLOYER'S FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

FOR USE BY INSURER/SELF-INSURER

B.
Average weekly wage: $ ______ Weekly benefit: $ ______ Date of disability: ______ Date of first payment: ______
Compensation paid: $ ______ Penalty paid: $ ______ Previously Medical Only Yes ☐ No ☐
BENEFITS ARE PAYABLE FROM ______ FOR:
☐ Total/temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ____ % to ______ Part of Body for ____ weeks
UNTIL ______ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

By ______ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

C. **NOTICE TO CONTROVERT PAYMENT OF COMPENSATION** (over for additional information)
Benefits will not be paid because:

By ______ (Insurer/Self Insurer: Type or Print Name of Person Filing Form and Sign) (Date) (Phone) (Extension)

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

* Just wanted it noted. - Did not want to see a Dr.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

FORM WC-1 REV. DATE 7/99

→ * called 5/1/00 & decided he wanted to see a pe - chose Dr. Ciepiela.

CONFIDENTIAL WCW 002617

VS
5/24/00

INITIAL VISIT EVALUATION
West Paces

PATIENT: Bobby Walker
DATE: May 4, 2000

HISTORY: Bobby was referred by WCW for evaluation and treatment of his left knee. Approximately a month ago, while in the ring, he caught a wrestler, twisted his knee and felt a pop. He had a large amount of swelling immediately. He rehabbed his knee with the swelling going down. He has however had additional episodes of giving way and swelling of his knee doing simple activities such as mowing his lawn.

EXAM: Examination of the knee reveals a 1+ effusion, range of motion is 5 to 110, he has 2 to 3+ Lachman's, 1+ pivot shift, 1+ anterior drawer, and positive medial joint line tenderness.

DIAGNOSIS: Probable anterior cruciate ligament tear with medial meniscus tear.

PLAN: The plan is to obtain an MRI of his knee to evaluate for pathology. He was given Celebrex samples to take to help with his current effusion. He will continue to rehab his knee since he is familiar with the appropriate exercises. Recheck will be after MRI is performed.

MDC:ls

Michael D. Ciepiela, MD

CONFIDENTIAL

Henderson, Debbie

From: Myers, Diana
Sent: Wednesday, June 07, 2000 9:18 AM
To: Henderson, Debbie
Subject: RE: Bobby Walker

keep a copy of this e-mail in the file.

dm

-----Original Message-----
From: Henderson, Debbie
Sent: Tuesday, June 06, 2000 4:43 PM
To: Myers, Diana
Subject: Bobby Walker
Importance: High

Yesterday I received a message from Sharon at One Call Medical (the CO. that schedules our MRI's, CT Scans, etc.) stating that Bobby was scheduled on 5/15 for an MRI and no showed that appt. Then he was rescheduled for 5/24 in which he called the location directly and cancelled. She says since 5/24 she has been trying to get in touch with him to reschedule again and he is not returning any of her calls or there is no answer at his home number. She asked me to see what I could do.

In trying his home today, I let him know that they have been trying to get in touch with him regarding getting the MRI done, and he stated the knee feels better, and that he wanted to wait on the MRI. He said he would call if he felt he needed to have it done after a couple of weeks.

Just wanted you to know.

Thank You!!

Debbie Henderson/WCW Risk Mgmt.
Ph-(404) 603-3118
Fax-(404) 603-4017
Cell-(404) 281-0622